
Transference-Focused Psychotherapy for Personality Disorders in Adolescence

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This chapter will focus on the adaptation of the adult transference-focused psychotherapy to personality disorders in adolescents (TFP-A). The model of personality disorders and their treatment is based on contemporary psychoanalytic object relations theory as developed by Kernberg (1984, 1992) and supported by findings from current evidence-based and neurobiological research (Clarkin, Levy, Lenzenweger, & Kernberg, 2004; Clarkin & Posner, 2005; Doering et al., 2010; Levy et al., 2006). In the first section we will examine the challenges of adolescents for the consolidation of personality and identity. This will be done using a perspective that integrates neurobiology with research and theory of affect, affect regulation and aggression, as well as sexuality. We will then present a contemporary object relations theory for understanding the development of personality disorders. This is followed with a section on “Assessment” and finally we will present our approach to the treatment with main tactics, strategies, and techniques.

Introduction

The prevalence of borderline personality disorder (BPD) in adolescents seems to be at least as high, if not higher than in adulthood (Chabrol,

Montovany, Chouicha, Callahan, & Mullet, 2001; Chabrol et al., 2004; Cohen, Crawford, Johnson, & Kasen, 2005; Johnson, Bromley, Bornstein, & Sneed, 2006; Lewinsohn, Rohde, Seeley, & Klein, 1997) due in part to the increased independence, exploration of new environments, and social responsibility at a time when neurobiological systems involved in constraint and planning to regulate impulsiveness are relatively immature. In spite of the high prevalence of BPD in adolescents, until recently child and adolescent clinicians have been cautioned not to apply the adult criteria to children and adolescents. This was partly due to concerns that behaviors that might be normative in children and adolescents might be misdiagnosed as signs of BPD. It was also because of important nosological concerns regarding whether the BPD diagnosis in childhood was in fact a precursor of adult BPD specifically, or a precursor of adult psychiatric disorder more generally (Kestenbaum, 2012). Due to the advocacy work of pioneers like Paulina Kernberg (Kernberg, Hajal, & Normandin, 1998; Kernberg, Weiner, & Bardenstein, 2000; Kernberg & Wiener, 2004), we know that a constellation of BPD type symptoms can be observed in childhood and are unlikely to resolve without intervention specifically targeting personality issues. Much further work is needed to shed light on BPD symptoms in children, to differentiate children at risk for developing BPD and other serious psychiatric disorders in adulthood, in order for them to receive appropriate treatment

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and medication especially during adolescence (Pettit, 1997), although work in this regard, as exemplified in the current volume, is underway.

Recent practice guidelines regarding diagnosis and treatment of children and adolescents with BPD recommend that the diagnosis using the adult criteria can be made reliably from age 13 (NICE Clinical Guidelines, 2009; Noorloos & Huijgen, 2011). Few clinicians who work with adolescents currently use the BPD diagnosis, although the majority agree that BPD can be diagnosed in adolescence (Laurensen, Hutsebaut, Feenstra, Van Busschbach, & Luyten, 2013). Today there is increasing recognition of the positive implications of early diagnosis as a way of recognizing the suffering of these young patients and their families, helping them to understand the problem and access appropriate treatment as early as possible. Moreover, a leading research group, Chanen, Jovev, McCutcheon, Jackson, and McGorry (2008), promotes immediate action for first presentation of BPD traits or disorder, similar to early intervention for first-episode psychosis.

The development of BPD is a lengthy multi-determined process with its roots in early childhood (Carlson, Egeland, & Sroufe, 2009; Lenzenweger & Cicchetti, 2005). There is a genetic contribution (Distel, Hottenga, Trull, & Boomsma, 2008; see also Chap. 11), but what is inherited is biological vulnerabilities involving a combination of genes (Skodol et al., 2002). In early infancy and childhood temperamental traits like negative affectivity, stress reactivity, and impulsivity (Goodman, New, & Siever, 2004; Posner et al., 2003) are linked to emotional vulnerability and an increase in risk of developing personality disorders (PDs), in interaction with environmental factors that influence gene expression. Both genetic and environmental factors are thought to have the most profound impact during the early postnatal period, a time when the forebrain is undergoing rapid growth (Depue, 2009). Themes of neglect and abuse associated with family dysfunction and parental psychopathology are common, especially when

family interactions are invalidating, conflictual, negative, critical (Fruzzetti, Shenk, & Hoffman, 2005), and nonempathic (Guttman & Laporte, 2000). Temperamental traits of extreme emotional intensity (i.e., the tendency to extreme reactions) and reactivity (i.e., high sensitivity to emotional stimuli) may also be an important, but as yet relatively less researched, vulnerability factor, and may help to understand the development BPD symptoms such as self-harm in the apparent absence of the usual risk factors. Findings from a rare longitudinal study by Carlson et al. (2009) on the development of BPD from infancy to early adulthood confirm that temperament and early histories of attachment disorganization, parental hostility and abuse, and family life stress are important risk factors. These factors predicted disturbances in many domains of functioning in middle childhood and early adolescence including attentional, emotional, and behavioral regulation as well as relationships and self-representation. Moreover the study findings underscore the important role of *self-representation* in early adolescence, showing that it mediated the relationship between attachment disorganization and BPD symptoms in early adulthood. We consider that disturbances in the organization of the self are central to the development of BPD and these disturbances will manifest in the core dimensions of the self involving negative affect, self-regulation, motivation, and reward, as well as control systems involving attention and reflectiveness, interpersonal interaction, and affiliation.

Disturbances in Organization of the Self

Our view is consistent with a developmental psychopathology perspective that emphasizes the organization of experience and patterns of adaptation, with borderline personality dysfunction reflecting “a disturbance in core dimensions of self-competence that interact and transact to

form the foundation of subsequent functioning” (Carlson et al., 2009). In this perspective the self is defined as an organization of attitudes, feelings, expectations and meanings, and manifestations in attention, behavior, and relationships. Positive adaptation is facilitated by the integration of biological, emotional, cognitive, and representational capacities that enable the child and adolescent to respond flexibly to current and future developmental challenges. Maladaptation or psychopathology reflects rigid patterns of responding that compromise development. Development is seen as a series of qualitative reorganizations within the framework set by early experience. In the context of interactions with responsive caregivers, children develop adaptive and flexible patterns of attentional and emotional regulation, and develop positive representations of self and others, and individual and interpersonal skills that help them maintain their self-organization and facilitate the maintenance of close supportive relationships with others. This provides the framework for further integration of developing cognitive and social capacities in interaction with the social world that is reinforced and structured by the parents.

Disorganized attachment and overwhelming emotional experience, such as trauma, disrupt the normal processes of organization and integration of self. The absence or breakdown of early dyadic regulation systems for establishing an affect regulation pattern that forms the basis of self-regulation is considered to be an important source of later adaptational vulnerabilities and long-standing difficulties in self-regulation (Liotti, 1999). Malevolent caregiving or caregiving characterized by contradictory cues or the frightened or frightening maternal affects described by Lyons-Ruth (2003) are considered to be disorganizing as they evoke intense emotional reactions and conflicting needs that overwhelm the immature regulatory capacities, and result in a collapse in regulatory strategies (Hesse & Main, 2000).

To summarize, children who have experienced overwhelming affect in the absence of attachment relationships, where their needs for security are responded to and where they are helped to regulate and develop the basis for

self-regulatory skills, are likely to develop long-standing difficulties in emotion and self-regulation. Unless they are in relationships where emotions are acknowledged and discussed they are unlikely to develop the capacity to know their strengths and weaknesses and develop balanced representations of others. These representational capacities are considered important for processing and top down regulation when emotions are evoked. Poorly developed emotional understanding and communication skills also place them at a further disadvantage when confronted by traumatic experiences, as they do not have the capacities needed to identify their feelings, and discuss their experiences and reactions.

Challenges of Adolescence for Personality

Adolescence is widely considered to be a critical period when key developmental tasks of attachment, self-development in strivings for autonomy, and emotional and behavioral self-regulation are reworked in the context of intimate relationships, identity formation, and management of risky behavior (Macfie, 2009; Sroufe, Egeland, Carlson, & Collins, 2005; Sroufe & Rutter, 1984). Despite the common portrayal of adolescence as a period of crisis with the adolescent weathering a storm of overwhelming affects and impulses, the majority of adolescents manage to engage with the challenges and opportunities of this period without any marked difficulties. Longitudinal research from the perspective of self-esteem, for example, shows that as many as 87 % of adolescents show consistently high and increasing self-esteem from early adolescence to early adulthood (Birkeland, Melkevik, Holsen, & Wold, 2012). They have an overall sense of continuity where they are able to integrate new roles and experiences on the way and arrive at the end of adolescence with a coherent sense of identity reflecting their own values and ideals. Most adolescents are able to resolve the inevitable confusion as their social and life experiences widen and confront them with new

ideas and opportunities that are challenging to integrate this into their existing identity. While their identity might become more nuanced in so far as they separate from their parents, develop social networks, and enter into their first romantic relationships, there is a strong sense of continuity of their personalities and the sense that they build on their childhood selves, rather than reinvent themselves, and that even as they become more independent and develop views and values that are more differentiated from their parents, they maintain their relationships with parents and family members. In addition, even where they develop views and values which may differ and in some cases be in conflict with that of their parents, they maintain a certain capacity to see past these differences and appreciate positive aspects of the parents and are able to turn to their parents for help in times of need.

In contrast, and based on clinical observation, the vast majority of adolescents who are diagnosed with BPD have childhood histories of long-standing and marked difficulties in affect and behavior regulation. Adolescents with relational disturbances, involving inappropriate aggression directed toward others such as oppositional deviant disorder (ODD) and conduct disorder (CD) during childhood, frequently meet criteria for BPD during adolescence. Some other adolescents with BPD may not have the same overt difficulties in behavior or affect regulation and aggression of ODD or CD, but may have a stable pattern of inflexible and maladaptive reactions. These maladaptive qualities might be difficult to observe in situations that are structured, non-challenging, or predictable; they are more likely to appear in periods of change and stress. For example, how the child handles the transitions between junior and high school, activities that make greater interpersonal demands such as making new friends and establishing a level of intimacy in a relationship or situations involving challenges, competition and the risk of failure and humiliation such as taking tests, team sports, or performing publicly at school, or that make new demands for autonomy such as a sleep-over, and finding a job and performing a job in the

absence of supervision. Consistent maladaptive reactions to these situations may be indicative of disturbances in characteristic defenses and coping mechanisms and these underlying difficulties will become more and more evident at each developmental period so that there may be definite but less flamboyant evolution toward a PD when faced with the inevitable challenges of adolescence to separate, become more independent, and establish social and intimate relationships outside of the security of the family.

Included in this group are adolescents who present with BPD who have childhood histories that seem at first glance unremarkable and without any apparent psychiatric difficulties, and who seemed at most to have been somewhat sensitive, dependent, submissive, and obsessional as children. Adolescents who develop eating disorders or engage in self-harm frequently have such apparently unremarkable childhood histories. We can conclude that these adolescents, like those with ODD and CD, have long-standing difficulties that have become over time entrenched into their personalities and increasingly evident in the context of demands to become autonomous, take on increasing responsibilities, and make decisions while at the same time separating from parents and developing new intimate relationships.

We consider that there is also another small group of adolescents without childhood psychological problems or personality difficulties who may develop identity crisis that is difficult to distinguish from BPD, at adolescence when they are confronted with overwhelming challenges and discontinuities that surpass their capacity to absorb and integrate this in a way that preserves a sense of continuity and coherence. In the longitudinal trajectory study of self-esteem by Birkeland et al. (2012) this group, representing approximately 7 % of adolescents, presents with an u-shaped trajectory where their initially good self-esteem decreases markedly between ages 14 and 18, reaching its lowest level at late adolescence, before improving during the next 5 years. This group of adolescents may either have pre-existing fragilities that compromise their capacities to adapt to change or their difficulties

during adolescence may lead to some kind of scarring, as their global self-esteem at age 30 is significantly lower than that of individuals with consistently high self-esteem during adolescence, and they present with significantly higher levels of depression. This would suggest that adolescents who experience identity crisis or sharp decreases in self-esteem may also warrant therapeutic interventions and potentially derive significant long-term benefits from therapy. Sexual abuse, including sexual abuse just before or at the beginning of adolescence, may be particularly destabilizing and this may be the final straw that breaks the camel's back for girls who may have shown resilient personality characteristics and who were able to continue function well at school and invest in friendships in the context of parental neglect, substance abuse, psychological problems, and immaturity. In addition to the range of PTSD symptoms that may be expected to resolve in due course, sexual abuse may interfere with the capacity of adolescent girls to form intimate relationships and to develop trust in partners.

Adolescents who engage in increased risk taking, especially where drugs, alcohol, and sex are involved, may also be more at higher risk of presenting with identity crisis and lowered self-esteem when they develop addictions or experience trauma or become overwhelmed when their behaviors take them down paths they are unprepared for. Another group that may be particularly at risk are those adolescents who are confronted with the task of assuming a sexual identity that is not culturally approved and confronts the adolescent with the possibility of being alienated from peers and family. In addition, for hypersensitive adolescents, parental separation, especially when accompanied by conflict and geographical moves to far away cities that make parents more difficult to access and which is associated with a loss of friends and challenges them to integrate into a new social circle and adapt to a new academic environments, can provoke breakdowns and identity diffusion which present like BPDs and is associated with the onset of suicidal and self-harming behavior. It is possible that parental mental illness, chaotic family environments where parents respond with inappropriate

physical aggression to adolescent self-assertion, and bids for separation can also lead to breakdowns that result in identity diffusion in sensitive or vulnerable adolescents.

Neurobiological Developments at Adolescence

From a neurobiological perspective, adolescence is considered to be one of the most optimal but at the same time vulnerable periods for the development of cognition, especially of higher order thinking, reasoning, problem solving, and risk taking (Reyna, Chapman, Dougherty, & Confrey, 2012; Steinberg, 2008). Over the period of adolescence and extending into early adulthood, dramatic brain changes take place in the frontal lobe regions that subserve reasoning, problem solving, decision making, and higher order reasoning. If these abilities are developing so rapidly during adolescence, why do adolescents seem more emotionally reactive and vulnerable to making bad decisions when against their better judgment and engage in risky behaviors, especially when under the influence of emotions and peers? Casey, Jones, and Somerville (2011) have proposed an imbalance model of adolescent brain development. They point out that during adolescence, the limbic system is functionally mature at a time when the prefrontal systems are still developing, so that adolescents are much more vulnerable to the influence of the reward-sensitive limbic. This is consistent with the widely used dual processing model which holds that people often use reflexive or automatic, intuitive affect-driven heuristic processes although they are capable of more reflective, controlled rational processes (Evans, Venn, & Feeney, 2002; Reyna, 2004). In neurobiological terms the reflexive processes are mediated by the affect-related subcortical systems while the reflective component is subserved by the prefrontal cortex (Galvan et al., 2012; Galvan, 2013). This model is supported by the increase in evidence that dual systems involving both cognitive and affective processes are involved in our evaluations of situations so that decisions result

from an interaction between more thoughtful processes and more experience-based, affective, heuristic, and motivational processes (Damasio, 1994; Epstein, 1994; Evans, 2008; Lerner & Keltner, 2000; Lieberman, 2000; Loewenstein, Weber, Hsee, & Welch, 2001; Schneider & Caffray, 2012; Stanovich & West, 2000).

From the dual systems perspective BPD pathology, including dysregulated negative affect, impulsive and aggressive behavior, and interpersonal difficulties, can be seen as related to deficits in the reflective and executive control processes, coupled with a biased reflexive process where there is an automatic hypersensitivity to negative social cues (Koenigsberg et al., 2009), an expectation of untrustworthiness (King-Casas et al., 2008), and increased negative affect (Sadikaj, Russell, Moskowitz, & Paris, 2010).

Affects, Affect Regulation, and Aggression

High levels of negative affect and difficulties in affect regulation are considered to be problems commonly experienced by individuals with BPD (Lenzenweger, Clarkin, Fertuck, & Kernberg, 2004). This is even more problematic during adolescence when the intensity of emotional states and visceral urges are amplified. In contrast to treatment models focusing more on cognition and cognitive interventions, we give a central place to affects, with a special emphasis on working with negative affects such as aggression and fear. Affect is considered to play a vital role in guiding behavior (Schneider & Caffray, 2012) with affect-laden intuitions acting as a fast and frugal heuristic (Gigerenzer, 2000) for quickly and automatically judging whether stimuli in the environment are positive or negative (Slovic, Finucane, Peters, & MacGregor, 2002, 2004). In patients with BPD reflexive social cognitive processing is distorted by negative affect especially in contexts that evoke threat. Given that attention and processing resources are likely to prioritize potential threats,

this might leave fewer resources for attentional and reflexive processes that can help with top down regulation.

Intense negative affect is also central in our conceptualization because we consider that it is at the heart of the mechanism of projection, which can be seen in cognitive terms as a process where the person does not recognize his/her own affects such as aggression, and is convinced that it comes from the other. Our treatment is specifically designed to stabilize extreme affects by systematically getting the patient to become aware of the split and polarized, positive and negative affective representations in peak affect states and under the impact of projection, and then to slowly integrate these representations. This reduces the extreme distortions in representation and cognitive processing maintaining and escalating the states of intense negative affect and making the resources of the cognitive system available to develop more accurate integrated representations of self and others.

Sexuality in Adolescence

The integration of sexuality into identity is one of the important challenges of adolescents. The physical and hormonal changes associated with puberty and sexual maturation challenge adolescents to integrate being sexually active into their previous prepubertal identity where sexuality was prohibited by parents and society. Sexual interest, first sexual experiences, falling in love and developing an intimate sexual and emotional relationship, and negotiating dependency needs in a close relationship with a partner are important developmental steps that have to be negotiated during adolescence. Adolescents with BPD and histories of physical, sexual, and emotional abuse within the family, especially where this is superimposed on preexisting difficulties in responding to their attachment needs, can be expected to find it difficult to develop sexual and emotional intimacy. They are known to have earlier onset of first intercourse, a higher risk of sexual victimization, and date rape

(Sansone, Barnes, Muennich, & Wiederman, 2008), but may also be at increased risk for perpetrating abuse (Zanarini, Frankenburg, Reich, Hennen, & Silk, 2005). In addition BPD is associated with greater risk taking in the sexual arena involving promiscuity and impulsively entering into sexual relationships. Others may experience sexual inhibition, avoidance (Zanarini et al., 2003), and fears related to physical and emotional intimacy that becomes a serious obstacle to establishing intimate relationships. In addition to personality, trauma-related factors are considered to be important for understanding these reactions (Trippany, Helm, & Simpson, 2006). Furthermore there is evidence that the onset of sexual relationships coincides with the onset of BPD symptoms in a third of BPD patients (Zanarini et al., 2003). Given the high probability of difficulties relating to risk taking, victimization, and intimacy in the area of sexuality, and the fact that these difficulties may emerge or be particularly pertinent during adolescence, we consider that clinicians need to be alert and open to exploring and thinking about difficulties in this area.

Adolescence is also a time when sexual identity or sexual orientation is defined. We consider that the question of sexual identity needs to be considered carefully when adolescents present with concerns in this area. While adolescents, like adults, with BPD may frequently switch between having sex with one gender to the other (Reich & Zanarini, 2008) it is important to identify those adolescents who are actually struggling with important difficulties around assuming their sexual identity, and treat them appropriately. Adolescents who become aware that they are not heterosexual may present with features that could potentially be confused with identity diffusion as they experiment and explore different sexual orientations and roles. The assumption of a homosexual identity is more challenging and takes longer, and is presumably only achieved by early adulthood, usually between the ages of 22 and 24 (Isay, 1986). Parental rejection and loss of the family as a support system may increase conflicts and anxieties about separation and becoming independent. Adolescents who experience acute

rejection and ejection from the family home are at risk for running away, are more vulnerable to engaging in prostitution and substance abuse (Sugar, 1997), at higher risk for attempting suicide especially when confronted with intimidation (Renaud, Berlim, Begolli, McGirr, & Turecki, 2010), and more likely to consult mental health services.

Identity, Identity Diffusion, and Identity Crisis

Identity is one of the central concepts in the area of personality development and is central in our conceptualization of personality disorders. It is the subjective part of personality, and self-understanding, self-concept, self-as-subject, and self-other differentiation are all terms that have been used at times, interchangeably with identity. While these constructs share many features, they are not necessarily synonymous. As Erikson (1968) stated earlier, identity consists of a sense of inner sameness, continuity within oneself and in our interactions with others over time, being distinct with others, and a sense of inner agency. It reflects the awareness of one's individuality and one's allegiance to the ideology and culture of his group. It implies a sense of purpose, intentionality, and mastery.

In Akhtar and Samuel's review of the concept (1996), identity is constituted of a realistic body image, an awareness of a core gender identity (male or female), gender roles (femininity or masculinity), and sexual orientation (heterosexual or homosexual), a subjective self-sameness across situations and smooth transitions between various self-representations emerging under diverse social circumstances, a temporal continuity, a true capacity to recognize the positive and negative traits in oneself and in others that conveys a sense of authenticity, an ethnic identity constituted of cultural values, verbal and nonverbal modes of expression, and patterns of interpersonal behaviors, and finally a conscience that reflects the capacity to respond to rewards and punishments, to experience remorse and guilt, and to work for ideals. By the same token, an integrated identity also involves an integrated

realistic view of significant others that tolerates the complex integration of positive and negative features of their personality, and the capacity to maintain such a view even under conditions of temporary conflict or mood-inflicted negative affective interactions with them.

In our opinion, school-aged children have already attained a good level of integration of these components. Indeed, identity is a lifelong process that has its roots in children's earliest interactions with the environment. Children's identification and introjects are precursors of the process of identity formation in adolescence. In fact, identity formation starts where the usefulness of identification ends. During adolescence, these components of identity are remodeled under the psychobiological changes. The adolescent feels himself in the grip of overwhelming instinctual impulses that he must rapidly learn to master. As stated by Jacobson (1964), "adolescence is life between a saddening farewell to childhood—i.e., to the self and the objects of the past—and a gradual, anxious-hopeful passing over many barriers through the gates which permit entrance to the as yet unknown country of adulthood" (p. 161). The adolescent must free himself from his attachments to persons who were all important during childhood; he must also renounce his former pleasures and pursuits more rapidly than at any former developmental stage. Preparing himself to leave home, he must reach out for adult sex, love, and responsibility, for personal and social relations of a new and different type, for new interests and sublimations, and for new values, standards, and goals as an adult. This necessitates a complete reorientation, leading to structural and energetic transformations, redistributions of emotional investment, and to a drastic overhauling of the entire psychic organization. This remodeling of the adolescent's identifications, values, and ideals and its interrelationship with the development of his new identity, feelings, and object relations find an echo in the states of his shifting mood and emotional turmoil.

An important diagnostic problem with adolescent is to differentiate between the syndrome of identity diffusion that underlies personality

disorders and the identity confusion (or crisis) that can be accounted for by normal development in adolescence (Erikson, 1968).

Identity crisis (confusion) refers to the frequent, time-limited dissociation between the perception of an adolescent of himself/herself, on the one hand, and the perception of that adolescent by the family and the social environment in general, not fully grasping the profound internal transformations occurring as part of puberty and adolescence. The lack of confirmation of the perception of self in the interactions with significant others may induce a sense of alienation and confusion in adolescents who, however, present a well-integrated view of their present self and an integrated view of significant others. An adolescent's conflicts around regressive dependency and rebellious assertion of autonomy may convey a picture of emotional instability and interpersonal conflicts that, however, may not correspond to a syndrome of identity diffusion.

Identity diffusion. In the case of identity diffusion, there is a general lack of integration of the concept of the self reflected in contradictory self-experiences that cannot be reconciled, serious distortions in the views of significant others, the typical development of sharply split, idealized, and persecutory object relations, and extreme oscillations of self-esteem. Moreover, the syndrome of identity diffusion typically is reflected in serious discontinuities in the self-concept and unrealistic evaluation and affective distortions in the relations with significant others, significant failure in the social life at school, in school performance, in the relations at home, serious dissociation between sexual behavior and emotional intimacy, and the possible development of antisocial behavior.

Integrated (consolidated) identity. An adolescent's capacity to describe an internal state of turmoil from the perspective of an implicit-integrated view of self, and an integrated view of the most important members of his/her family in spite of turmoil and conflicts in their relations, the presence of a well-integrated system of moral and ethical values, the commitment to ideals beyond self-serving objectives, the capacity for friendships in depth with peers, good functioning

at school, and evidence for the capacity of romantic love, all point to the presence of an integrated identity. He/she has attained a level of self-reflection (or mentalization) that permits this self-examination.

Definitions and Core Constructs Using a Psychodynamic Perspective

In essence we consider that patients with BPD suffer from identity diffusion where their representations of self and significant others are polarized and unstable and may oscillate rapidly from idealized to persecutory. We consider that affect, and particularly negative affect, and the predominance of aggressive internalized object relations over idealized ones (Kernberg, 2006) are central to this failure of psychological integration and interfere with the use of mentalization and impede the development of integrated representations of self and others. This is because, in an effort to protect the idealized segment of self and other representations, these patients use dissociation and splitting mechanisms as well as other primitive defenses such as projection, projective identification, omnipotence and omnipotent control, devaluation, denial, and primitive idealization. Identity diffusion manifests clinically in the incapacity to have a reasonably accurate and nuanced assessment of self and others, a lack of understanding, empathy, and the normal tact in interpersonal situations, and incapacity to maintain intimate relationships and commit in depth to work.

Contemporary Object Relations Theory

A fundamental premise of this psychodynamic conceptualization and treatment of adolescents with personality disorders is that the observable behaviors and subjective disturbances reflect pathological features of underlying psychological structures. A psychological structure is a stable and enduring pattern of mental functions that organize the individual's behavior,



Fig. 22.1 Object relation dyad: self–other representations linked by affects

perceptions, and subjective experience. A central characteristic of the psychological organization of adolescents with severe personality disorders is the lack of integration of the psychological structures of an integrated conceptualization of self and of significant others, that is the syndrome identity diffusion.

In object relations theory it is emphasized that the drives described by Freud—libido and aggression—are always experienced in relation to a specific other: an object. Internal object relations are the building blocks of psychological structure and serve as the organizers of motivation and behavior. These basic building blocks of psychic structure are units made up of a representation of the self, an affect related to or representing a drive, and a representation of the other (the object of the drive). These *units of self*, *other*, and the *affect* linking them are referred to as *object relations dyads* (Fig. 22.1). It is important to note that the “self” and the “object” in the dyad are not accurate internal representations of the entirety of the self or the other, but rather are representations of the self and other as they were experienced in specific affectively charged moments in time in the course of early development in primary attachment relationships, and defensively distorted in the course of intrapsychic development.

The individual with a normal personality organization has first an integrated concept of self and of significant others which is captured in the concept of identity. This concept includes both a coherent internal sense of self and a pattern of behavior that reflects self-coherence. Such a coherence of self is basic to self-esteem, enjoyment, and the capacity to derive pleasure from relationships with others and from commitment to work, school, or other responsibilities. A coherent and integrated sense of self contributes to the realization of one's capabilities, desires,

and long-range goals. Likewise, a coherent and integrated conception of others contributes to a realistic evaluation of others involving empathy and social tact. An integrated sense of self and significant others permits the development of intimacy and stability in love relationships and the harmonious integration of tenderness and eroticism in such relationships.

In essence, our basic assumption in the application of contemporary object relations theory is that all internalizations of relationships with significant others, from the beginning of life, have different characteristics under the conditions of peak affect interactions and low affect interactions. Under conditions of peak affect activation—be they of an extremely positive, pleasurable or an extremely negative, painful mode—specific internalizations take place framed by the dyadic nature of the interaction between the baby and the care-taking person, leading to the setting up of specific affective memory structures with powerful motivational implications. Object relations theory assumes that these positive and negative affective memories are built up separately in the early internalization of these experiences and, later on, are actively split or dissociated from each other in an effort to maintain an ideal domain of experience of the relation between self and others, and to escape from the frightening experiences of negative affect states. Negative affect states tend to be projected, to evolve into the fear of “bad” external objects, whereas positive affect states evolve into the memory of a relationship with “ideal” objects. This development evolves into two major, mutually split domains of early psychic experience, an idealized and a persecutory or paranoid one, idealized in the sense of a segment of purely positive representations of self and other, and persecutory in the sense of a segment of purely negative representations of other and threatened representation of self. This early split experience protects the idealized experiences from “contamination” with bad ones, until a higher degree of tolerance of pain and disappointment, and more

realistic assessment of external reality under painful conditions evolves.

This early stage of development of psychic representations of self and other, with primary motivational implications—move toward pleasure and away from pain—eventually evolves toward the integration of these two segments, an integration facilitated by the development of cognitive capacities and ongoing learning regarding realistic aspects of self and others interacting under circumstances of low affect activation. The normal predominance of the idealized experiences leads to a tolerance of integrating the paranoid ones, while neutralizing them in the process. In simple terms, the child recognizes that he/she has both “good” and “bad” aspects, and so does mother and the significant others of the immediate family circle, while the good aspects predominate sufficiently to tolerate an integrated view of self and others.

This state of development, referred to by Kleinian authors (Klein, 1940; Segal, 1964) as the shift from the paranoid-schizoid to the depressive position, and by ego psychological authors as the shift into object constancy, presumably takes place somewhere between the end of the first year of life and the end of the third year of life. Here, Mahler’s (1972a, 1972b) research on separation-individuation is relevant, pointing to the gradual nature of this integration over the first 3 years of life.

Peter Fonagy’s (Fonagy & Target, 2003; Bateman & Fonagy, 2004, 2006) referral to the findings regarding mother’s capacity to “mark” the infant’s affect that she congruently reflects to the infant points to a related process: mother’s contingent (accurate) mirroring the infant’s affect, while marked (differentiated) signaling that she does not share it while still empathizing with it, contributes to the infant’s assimilating his/her own affect while marking the boundary between self and other. Under normal conditions, then, an integrated sense of self (“good and bad”), surrounded by integrated representations of significant others (“good and bad”) that are also differentiated among one another in terms of

their gender characteristics as well as their status/role characteristics, jointly determines normal identity.

One central consequence of identity diffusion is the incapacity, under the influence of a peak affective state, to assess that affective state from the perspective of an integrated sense of self. The particular mental state may be fully experienced in consciousness, but cannot be put into the context of one's total self-experience: this implies a serious loss of the normal capacity for self-reflection, that is, for mentalization: under conditions of a peak affect state, a balanced and integrated representation of self and other is not possible.

This state of affairs has an important implication for the technique of TFP: the interpretation of splitting and other derived primitive defensive operations that bridge the emotional barrier between contradictory but conscious mental states fosters mentalization by integrating the mutual split representations of self and others. The development of an integrated representation of self facilitates the self-reflective function regarding the particular peak mental state under consideration. In short, interpretation of primitive defense mechanism fosters mentalization.

The major proposed hypothesis regarding the etiological factors determining severe personality disorders or borderline personality organization is that, starting from a temperamental predisposition with the predominance of negative affect and impulsivity or lack of effortful control, the development of disorganized attachment, exposure to physical or sexual trauma, abandonment, or chronic family chaos predispose the individual to the abnormal fixation at the early stage of development that predates the integration of normal identity: a general split persists between idealized and persecutory internalized experiences under the dominance of corresponding negative and positive peak affect states. Clinically, this state of affairs is represented by the syndrome of identity diffusion, with its lack of integration of the concept of the self and the lack of integration of the concepts of significant others.

Assessment

A careful diagnostic assessment is an essential precondition for the indication of the TFP-A treatment, and that assessment must include (1) the assessment of the adolescent symptomatology and behaviors; (2) the exploration of the parents' current maintenance of, as well as conflicts with, the adolescent's behaviors and symptoms; (3) a thorough developmental history to identify the roots of the disorders; and (4) the assessment of the adolescent's level of personality integration as reflected in the moment-to-moment interactions with the interviewer, his functioning at school or work, and through his peers and other social relations. The main goal is to get an as complete as possible picture of the adolescent level of functioning and level of personality organization and to distinguish his perturbations between normal identity confusion commonly encountered at adolescence and identity diffusion that is associated to personality disorders and to which this treatment is focused.

Assessment of the Adolescent Symptomatology and Disturbed Behaviors

The diagnostic criteria for a personality disorder as identified in the DSM-IV (American Psychiatric Association, 2000) (and now the DSM 5) are used for the assessment of PD in adolescents with an additional criterion that the onset must be traced at least to the early school years to respect the basic definition of PD as enduring maladaptive patterns of thinking, feeling, and behavior that are relatively stable over time.

Parental Contribution or Maintenance of the Disorder

As Freud (1905) stated, the adolescent detachment from parental authority, even though painful, is one of the most significant and necessary psychic achievements of the human mind. The adolescent

has to loosen his bonds with his family to be able to gain the instinctual freedom, a sense of autonomy, and to be able to assume full responsibility for his actions, thoughts, and feelings. Parents' roles are twofold: both to foster connectedness with their adolescent, and to encourage realistic steps toward autonomy, exploration of choice, speaking out, and questioning parental values. However, parental attitudes may convey a resistance to the adolescent's effort to separate or, on the contrary, underestimate or neglect the importance to accompany the adolescent through this delicate and anxiety-driven process. These parental attitudes may contribute to the development or to the maintenance of the disorder or, in severe cases, engender pervasive disturbances over the adolescence period (see Jacobson, 1964, pp. 200–209).

The therapist has to look for parental attitudes that did not permit the child's normal individuation or foreclose the adolescent's normal separation. For example, contradictory emotional and educational parental attitudes, early experiences of severe disappointment and abandonment, having grown up in an atmosphere of emotional poverty because of parents' personality disorders, emotional instability, confusion, or incapacity to love, or inordinate or repressive attitudes toward the adolescent's sexual behavior.

Developmental History: Assessing High Risk for Development of PD

Most of the personality disorders in adolescence can be traced back into infancy and childhood periods either through temperamental dispositions or through environmental hazards. In the patient's history, the clinician looks for indications of high risk factors for the development of PD. We look in the child history for signs of temperamental predisposition to the predominance of negative affect and impulsivity or lack of effortful control. On the environmental side, we look for signs of development of disorganized attachment, exposure to physical or sexual trauma, abandonment, or chronic family chaos predisposing the adolescent to the abnormal fixation at the early stage of development that predates the integration of normal identity.

The Personality Assessment Interview

There are different ways to get a clinical impression of the adolescent's sense of his personality, self, or identity. His actual behaviors, verbal and nonverbal, in the interaction with the examiner are a valuable source of information. He can also be asked to describe himself and significant figures such as parents, teachers, or friends with questions such as the following: (1) Can you describe yourself? (2) How do you see yourself physically, in front of the mirror? (3) How do you feel about changes in your body? (4) Can you describe your parents? and (5) Can you describe your best friend?

The Personality Assessment Interview (PAI), developed by Selzer, Kernberg, Fibel, Cherbuliez, and Mortati (1987) and derived from the structural interview developed by Kernberg (1981), focused specifically on the moment-to-moment interaction between the interviewer and the adolescent. The underlying hypothesis of the interview is that the patient's experience of the interview taps into his fantasies and influences his style of interaction with the examiner. The 60-min interview is conceived to elicit the basic components of the personality and its governing principles of organization and adaptation. The PAI technique consists of systematically asking questions that involve self-representation, object representation, mentalization capacities, affects, and cognitions as the patient talks. The interviewer asks at the beginning of the session: (1) what have you been told about this interview or meeting with me? and subsequently in the session: (2) now that we have been together for 15 min or so, how does what happened compare with your initial impressions, and what do you expect the rest of the meeting will be like?; and (3) What have you learned about yourself, about me, and what do you imagine I have understood so far?

The PAI is well suited for adolescents because the interviewer does not inquire about their private life. Furthermore, it helps to differentiate between normal identity confusion and elements of identity diffusion by giving signs of a preserved sense of self under challenging interactions.

Finally, the PAI helps to assess the capacity of the adolescent to benefit from psychotherapy, and specially TFP-A, because it taps such functions as attention, memory, reality testing, mentalization, and the capacity to sustain a working alliance under high affective interactions.

At the end of the assessment sessions, the therapist offers his understanding of the problem, and gets a sense of the capacity of the adolescent to recognize that he has a problem and whether he is able to commit himself to coming independently to sessions. This working toward a recognition and acceptance that there is a problem is in many ways a precondition for a successful treatment, as the adolescent is unlikely to be motivated to make a commitment to the therapy. The adolescent is much more likely to recognize that he has a problem when the therapist reformulates his behavior as internally, unconsciously, or developmentally motivated, and something which he does not have control of, or does not want to have control of, at the moment. We recommend TFP-A when there is the combination of the adolescent's capacity to take some responsibility for his own problems and to see that he needs to work to solve them and of little evidence of an antisocial personality disorder proper and few secondary gains from the illness.

Treatment

TFP-A is a psychodynamic treatment for borderline adolescents delivered in individual sessions ideally twice a week but not less than once a week (TFP-A manual available on request). The major objectives of the TFP-A are gaining better behavioral control, increasing affect regulation, developing more intimate and gratifying relationships with family, peers, or close friends, and engaging in a productive life as well as investing in school and future goals. This can be achieved through the development of integrated representations of self and others, the modification of primitive [defensive operations](#), the resolution of identity diffusion that participates in the fragmentation of the adolescent's internal world, and recognizing

and facilitating every attempts made by the adolescent to face normal developmental challenges which are often confounded or hijacked by the pathology itself. TFP-A interventions are composed of a series of tactics, strategies, and techniques geared to achieve these goals.

Tactics: Contracting and Setting the Priorities

The treatment tactics are the tasks the therapist must attend to in every session to create the necessary environment for the therapeutic work. They include how to prevent and address complications that may arise in the course of the treatment and how to choose the priority theme to address.

Contracting

The first key tactical aspect of TFP-A is establishing a contract between the adolescent, his/her parents, and the therapist. The contracting phase serves two purposes: first, to create the conditions for the therapist's position of neutrality which is the necessary precondition for the analysis of the transference, and second, to establish a treatment frame that protects the adolescent and the treatment from dangerous acting out, unconstructive parental involvement and considers the particular reality of the adolescent in terms of relations to home, school, and street.

Neutrality and authority. Adopting a position of technical neutrality requires open and direct spelling out of the boundaries of the treatment situation and their rationale to the adolescent and his parents, and an active, patient, and persistent educational work with the parents around the fact that they continue to maintain full authority outside the treatment sessions. The therapist may provide recommendations regarding some problematic interactions at home, but assumes no executive authority in this regard. The authority of the therapist is limited by the spatial boundaries of his office; what happens outside may trigger his counsel or advice, but is not his responsibility. Setting up regular joint meetings with the adolescent and parents should permit

them to ventilate many of problems that emerge. For example, some parents may abandon their responsibilities, “dumping” the patient in the hands of the therapist; or else, parents may feel envious and resentful of the therapist’s influence on their child, threatened by the therapist’s potentially undermining their authority, or by the therapist’s not sharing their particular ethical values and moral demands involving their child. In the case of female adolescents, parents may strictly forbid all sexual behavior—while the adolescent acts out her rebellion in unprotected sex, the therapist may have to help the parents find a more effective way to protect their child. Full discussion of all issues regarding authority in the joint meetings of adolescent, parents, and therapist should permit such a gradual clarification and assurance of the therapist’s position of technical neutrality, and permit teasing out the adolescent’s developing transference reactions.

Parent involvement and parental authority. Contract setting also requires agreements involving the parents and sometimes the school and even legal authorities, in addition to the direct contract setting with the adolescent. The fact that parents keep their legal authority until the adolescent’s majority gives them the right to be informed on a regular basis of his progress and the evolution of the treatment. However, the therapist has to create a space protected from the parents’ intrusion where the adolescent can have the experience of autonomy and individuation. The therapist needs to systematically address all the behaviors that can put this space in jeopardy, and help to identify strategies that will protect the treatment from unnecessary intervention from the parents. This is not an easy task and requires good clinical judgment from the part of the therapist because parents also may need to carry out significant controls of the adolescent’s life outside the sessions involving school, social life, the street, and the adolescent’s family and friends. Borderline adolescents tend to evoke powerful emotional reactions in their family that will influence the family’s transference reactions to the therapist, and represent a heightened influence on the treatment by the adolescent’s transference acting out

involving his family, including their willingness to collaborate with the treatment in terms of facilitating the adolescent’s coming to sessions, being responsible regarding financial arrangements, and following through with jointly agreed-upon structuring of the adolescent’s life outside the sessions.

Parents may need help with adolescents’ efforts at omnipotent control at home, with severe acting out at home or in relation to the school. Sometimes conflicts between the parents may be expressed in their lack of clarity regarding the support for the treatment, the responsibility for the adolescent’s attendance, payment, and the responsibility for both of them to attend scheduled joint meetings with therapist and adolescent. Sometimes the suggestion may be made that parents enter into couple therapy. In the case of separated or divorced parents, all these difficulties may become even greater.

Confidentiality. Another important issue at the contracting stage is confidentiality, how adolescents’ and family “secrets” are to be handled, and collateral sources of information. The general principle should be that all information regarding the adolescent and its sources should be shared with the adolescent himself. All the material from the sessions of therapist and adolescent is confidential, with the exception of issues that the therapist considers essential to protect the adolescent and the treatment. If information is to be shared outside the treatment, the adolescent would be informed first about that intention by the therapist to provide the possibility of a full discussion before the therapist proceeds. In those cases, it would be the responsibility of the therapist to indicate why such action seems to him essential to protect the adolescent’s social standing, physical health, psychological well-being, or even survival. This, of course, is particularly relevant with adolescents who present chronic suicidal and parasuicidal behavior, where the responsibility of the therapist, the adolescent, and the family has to be clearly spelled out. On this latter difficult issue, we follow Yeomans, Clarkin, and Kernberg’s (1992) suggestion for the treatment of adult BPD patients.

Setting the Priorities

A second crucial tactical aspect of TFP-A is setting the priorities and determining a sharp focus on what is going on in the sessions itself.

The priorities for interventions are similar to those of adults and derived from danger signals that override the general criteria for selection of material to be explored: First, threat to life, particularly suicidal intentions or behavior. Second, threat to treatment, represented by both refusal to come to sessions and indirect indications that patients and family are considering its disruption. Third, deceptiveness in the hours, indicating a predominance of “paranoid” or “psychopathic” transferences that need to be explored. In general, chronic deceptiveness takes a high priority for elaboration over an extended period of time in some cases, and regularly reveals underlying paranoid transferences: the adolescent fears that to “confess” certain issues or feelings would provoke criticism, rejection, retaliation, or punishment by the therapist, parents, or others. Fourth, severe acting out, either inside the sessions or outside, usually indicates affective dominance of the related material, and needs to be explored in the transference to being the material into the verbal realm. Fifth, trivialization: sometimes, the only thing the therapist can diagnose is that the content of the hours seems to be trivial; there is no particular affect activation nor affect “freezing,” both transference manifestations and countertransference dispositions are relatively quiet, and the question may be raised with the adolescent: what are we talking about? What is the relevance of all this? Are we leaving out important issues? In other words, the “looping” technique (reflecting on the recent interaction) may be used to interpret the defensive functions of trivialization.

The selection of material to be explored depends on what is predominant in the adolescent’s affect, and, if that is not clear, what is predominant in the transference, and, if that were not clear either, what is predominant in the countertransference. At the same time, the awareness of the problems in reality that are dominant in the adolescent’s life permits the

therapist to intervene regarding these issues even in sessions in which affect dominance does not appear clearly.

The frequent stimulation of the adolescent in terms of what his/her reactions are to what is going on in the session and to what has been discussed, the adolescent’s thoughts about what has been happening in the session, all are ways to stimulate the adolescent to explore his/her self-experience and the experience of the therapist’s interventions in the session. Following the therapist’s interpretive efforts, his raising the question with the adolescent, what is his/her understanding of why the therapist has said what he said, and a repetition of certain subject matters in this “reflective loop” may apparently reduce the amount of material that can be taken up in each session, but, in fact, increases the possibility of helping the adolescent to become aware of his mental states and of the mental states of the therapist, the process of “mentalization.” In the process, the therapist may evaluate the adolescent’s self-representations and object representations, their projections, the intensity of affect activation, and the extent to which the adolescent’s cognition is framing his affective experience and giving evidence of the adolescent’s developing reflective capacity and empathy.

External reality. A major tactical focus in adolescent TFP-A is the attention to external reality: where the adolescent stands regarding his/her actual developmental tasks. How is he/she doing at school, at home, in social life, and regarding personal well-being? Borderline adolescents who are involved with drugs, alcohol, cutting behavior, and neglect of their self-care in daily life require careful monitoring of these behaviors, and ongoing evaluation of their implications in terms of transference acting out. Transference analysis and consideration of external reality have to remain closely linked. As mentioned before, the therapist’s awareness of dominant problems in the adolescent’s relation with reality helps bring in those issues at times when intense transference–countertransference turbulence seems to direct the focus of the

treatment almost exclusively onto what is going on in the sessions.

Sexuality and erotic life. A sensitive tactic and particularly important focus in TFP-A is the adolescent's erotic life, an area that is a conventional cultural taboo in terms of communications between adolescents and adults, and may emerge only in subtle indirect ways in erotic behavior in the session, in erotic countertransferences, and in a clear discrepancy between the adolescent's erotized behavior on the one hand, and complete absence of information regarding erotic experiences and behaviors in the adolescent's external life, on the other. The management of erotic transferences may present a difficulty in terms of showing up in countertransference reactions while the adolescent studiously avoids any reference to his/her erotic fantasy or behavior. Tactful pointing out of the erotic implications of the adolescent's behavior in the hour, and its contrast with no reference to erotic experiences outside the hours, as if an important aspect of life were missing in the adolescent's experience, may bring the subject into full exploration. Here, direct, open discussion of sexual issues in a non-erotized context, and without taking the side of "superego" determined criticism nor rebellious stimulation of "sexual freedom" permit opening up this important area of adolescents' life experience, including the difficulty talking about sexual inhibitions, polymorphous sexual behavior and fantasies, and confusion and anxieties over their sexual wishes or inhibitions.

Affect storms. The development of affect storms is a particularly frequent complication and tactical challenge in the treatment of adolescents. The adolescent should be free to express his/her affects in the hour as long as there is no physical attack on the therapist or the office, nor sexual behavior during the sessions, and the adolescent's voice volume is contained by the office door and arrangements. It is important for the therapist to respond in affective terms that correspond to the affect activation of the adolescent, without entering into

yelling matches nor impulsive affective expression himself. In the case of opposite developments, with severe affective freezing and inhibition, the therapist has to be prepared to gradually interpret the transference implications of that development as well. At times, severe affect freezing is a defense against the potential of a strong affect storm.

Acting out. A major tactical task, at times, is to systematically analyze acting out outside as well as within the sessions, in order to transform it into a cognitively framed emotional experience that can be shared and jointly explored in the sessions. By the same token, the transformation of severe somatization into an equally shared cognitively framed affective experience that can be explored in the transference is an application of the same principle. Splitting processes in adolescents often take the form of a dissociation between severe acting out, on the one hand, and completely "non-related" affective reactions, anxiety, and depression, on the other. For example, an adolescent may have presented serious failures in school, and gross neglect of work that threatens him/her with academic failure, on the one hand, with no apparent concern and worry about it, and, on the other, nightmares or unexplained anxiety without any apparent content. Here, the major task is to overcome the mutual splitting of acting out and its corresponding affects, often linked with other defensive operations such as denial of the potential destructive effects of acting out behavior, and the unconscious enactment of guilt over competitive, self-assertive, or sexual gratification.

Strategies: Toward Integration of Split-Off Internalized Object Relations

The treatment strategies have to do with the long-term objectives of the treatment and are geared toward the integration of the "split-off" internalized self and other representations. They are guidelines to stay focused on the main task of

working on the adolescent's internal world even though the therapy session or the external life is chaotic.

Activation of Split-Off Object Relations

The main strategy of TFP-A consists in the facilitation of the (re)activation in the treatment of split-off internalized object relations of contrasting persecutory and idealized nature that are observed and interpreted as they are experienced in the transference. As in the adult treatment, the adolescent is instructed to carry out free association. The therapist restricts his role to careful observation of the activation of regressive, split-off relations in the transference, to help the adolescent to identify them, and to interpret their segregation in the light of his enormous difficulty in reflecting on their own behavior and on the interactions they get involved in.

Identity integration. The strategies revolve around the central object of identity integration as it is facilitated by the interpretive process to be described below. The interpretation of split-off internal states is based upon the assumption that the activation of one particular internal dyad determines the adolescent's perception of the therapist at any given moment. Activation of a dyad can involve rapid role reversals of the self and object representations that comprise the dyad: the adolescent may identify with the role of victim while projecting a corresponding object representation onto the therapist, while, 10 min later, he might angrily threaten the therapist who then is in the role of the victim. Engaging the adolescent's observing ego in this phenomenon paves the way for interpreting the conflicts that keep his internal world fragmented. After the adolescent's identification with both poles of a given dyad is explored, the work can address conflicts between opposite dyads—those reflecting the persecutory segment of the internal world and those representing the ideal segment. These dyads, and the corresponding views of self and other, are separate and exaggerated. Until these representations are integrated into more nuanced and modulated ones, the adolescent will continue to perceive himself and others in exaggerated, distorted, and rapidly shifting terms. As we noted, the oscillation or alternative

distribution of the roles of each dyad has to be differentiated from the split between opposite dyads carrying opposite affective charges. The final step of interpretation consists in linking of the dissociated positive and negative transferences, leading to integration and the resolution of identity diffusion.

The resolution of identity diffusion facilitates the modulation of intense affect dispositions as primitive euphoric or hypomanic affects are integrated with their corresponding fearful, persecutory, aggressive opposites. There is a significant integration of the adolescent's ego identity, as an integrated view of self—more complex, rich, and nuanced than the simplistic and extreme split-off self-representations—and a corresponding integrated view of significant others replace their split-off previous nature, and an experience of appropriate depressive affects, reflecting the capacity for acknowledging one's own aggression that had previously been projected or experienced as dysphoric affect, with concern, guilt, and the wish to repair good relationships damaged in fantasy or reality, becoming dominant. This step also brings about the mutual penetration and toning down of extreme, opposite affect states linked to all these representations. There is an increased capacity for affect control by the strengthening of their cognitive context as a consequence of the integration of self and object representations. In short, significant increase in cognitive framing of affective states improves mentalization—the capacity for realistic assessment of mental states of self and significant others, together with impulse control and enrichment of the overall subtlety and complexity of the assessment of social interactions. We will discuss how TFP-A then helps the adolescent use improved mentalization to resolve internal conflicts.

When severe identity diffusion and the corresponding splitting in transference developments are gradually overcome, the sessions may become more differentiated in their emotional implications, and acting out decreases. Severe turmoil in the sessions, while the external life of the adolescent normalizes, is a good indicator of progress in the strategic efforts of the therapist.

Techniques: Interpretation, Technical Neutrality, Transference, and Countertransference

The treatment techniques are the tools the therapist uses to address what is happening in the here and now in the service of accomplishing the overall strategy of integration.

The techniques of TFP-A are the same techniques described for adult TFP, with differences regarding the intensity, time dimension, and respective dominance of some of these technical approaches. They include interpretation, transference analysis, technical neutrality, and countertransference analysis.

Interpretation

The stages of interpretation include (1) clarification, that is, clarification of the communication of the adolescent, trying to reach the limits of the adolescent's self-awareness, before contributing with additional observations from the therapist; (2) confrontation, that is, tactful exploring of contradictions within the adolescent's communication, including his nonverbal behavior; and (3) interpretation per se, that is, formulation of a hypothesis regarding the unconscious implications of what has been clarified and confronted: first, in the unconscious meanings in the "here and now," and, only later, regarding the corresponding unconscious meanings in the "there and then."

Clarification. In TFP-A, clarification acquires a particular importance, and is an extended technical approach, practically in each session. The technique of exploring in "loops" what the adolescent thinks about what he has said, about the reaction of the therapist, where the adolescent stands now regarding what he has said, all this involves clarification in the sense of an exploration of the adolescent's conscious and preconscious awareness of his mental state. It is an essential technique leading to "mentalization," that is, a clearer understanding of the affective state of self and others as a motivational affective development. As mentioned before, clarification includes significant aspects of the adolescent's

life outside the sessions, and the utilization of expressions of the adolescent that stem from sources such as diaries or literary productions, drawings, and the adolescent's detailed description of important friends and people in his environment. The adolescent's enthusiastic wishes to tell about experiences he has had outside the sessions are encouraged to lead to detailed narratives, within which the adolescent's reactions and reflections may then be explored.

Confrontation. Equally, confrontation becomes a very important technique, and, particularly in the early stages of treatment, the focus on the adolescent's behavior in the sessions, inviting the adolescent to explain whatever caused the attention of the therapist, and inviting him to reflect on his own attitudes as he is developing a narrative in the session, all are important roads to exploring transference dispositions. This does not, however, necessarily lead to immediate transference interpretation, but, rather, to the relationship of what evolves in the session with the adolescent's behaviors outside the hours, thus facilitating the analysis of transference dispositions expressed toward third parties before direct interpretation of the transference in relation to the therapist. In a somewhat different sense, confrontation in the sense of challenging may also become an important technique in the case of significant secondary gain that may have to be vigorously questioned and resolved in order for it not to become a major obstacle to the treatment progress. For example, the therapist questions the adolescent's failure to do his homework, smoking pot at school, and putting him at risk sexually, and then considers what can be done to avoid placing both the adolescent and his treatment at risk. Discussion often leads to the understanding that these behaviors are resistances to experiencing parts of the internal world. These situations are quite challenging because the therapist may have to abandon momentarily his therapeutic neutrality in order to protect treatment and adolescent.

Interpretation. As mentioned before, interpretation starts out very carefully with extra-transferential interpretations, and tentative

efforts to link the content of different sessions, establishing a continuity of contents that originally may have been presented split off from each other. The therapist starts with what is affectively dominant in each session based on the therapist's combined assessment of the adolescent's verbal communication, nonverbal communication, and the countertransference. In the early stages of the treatment, much of the information is carried by nonverbal behavior and the therapist's countertransference reactions.

The therapist also follows the principle of interpreting from surface to depth, from the defensive sides of the conflict to the impulsive side of it, a general principle of psychoanalytic technique that becomes particularly important in adolescents, given the risk of adolescents receiving any new information brought in by the therapist as an authoritarian "brainwashing." It is important to start out with observations shared by the adolescent and the therapist regarding the reality of a certain fact that the therapist then may develop in further depth. If, to begin with, no common element of thinking or appreciation may be found regarding an issue the therapist thinks is important, the interpretation may have to begin simply with the therapist sharing with the adolescent that he has a particular view about a certain issue but believes that the adolescent may have a different one, and is interested in sharing with the adolescent the fact that there are two potentially incompatible views of that issue. In general, analyzing the defensive function before the deeper, impulsive one of a certain conflict is facilitated by the fact that the defensive operations are closer to consciousness than the dissociated, projected, or repressed ones. The formulation of the defensive aspect, its motivation, and only then, what it is defending against can be facilitated by a tentative, open-ended style of communication of the therapist's thinking, always sharing it as something to be examined in the same way as a statement of the patient. All of what has been said makes interpretation a slowed down process, or rather, it assumes a lengthy preparatory process that only culminates with the hypothesis about an unconscious

meaning once abundant evidence on the road to that interpretation has already emerged.

Technical Neutrality

Technical neutrality has been defined as intervening from a position that is equidistant to the sides of a patient's internal conflicts, as from the viewpoint of an "observing third party" (Clarkin, Lenzenweger, Yeomans, Levy, & Kernberg, 2007). Technical neutrality implies equidistance from impulses, prohibitions against impulses, the acting ego, and external reality, and an identification not only with the observing part of the adolescent's ego but also with general humanistic values that favor and support life, respect for the individual, physical health, and emotional well-being. Technical neutrality does not imply a cold, rejecting, or uninterested objectivity, but a warm, concerned, objective way of looking at the adolescent's internal conflicts. It is an essential position for the therapist in order to be able to analyze credibly transference developments. It doesn't imply a lack of countertransference reactions—even intense ones—as long as the therapist's interventions occur at a point where he has regained his internal objectivity.

Technical neutrality may have to be abandoned temporarily when the adolescent's well-being, the treatment, or others are threatened. In that case, the therapist may have to intervene with limit setting, and has to be prepared to follow up, over a period of time, with exploring fully the reasons for which he had to abandon technical neutrality, the significance of the conflicts that were activated in this context, all of it leading to the gradual analytic interpretive reinstatement of technical neutrality. Structuring, limit-setting interventions that involve the adolescent's home, school, or social life, may create significant and unavoidable complications to the therapist's efforts to reinstate his position of technical neutrality. Under conditions when the adolescent's sexual behavior, drug or alcohol abuse, antisocial behavior, or problems with the law requires energetic interventions from the parents, and these interventions may be

complicated by authoritarian, even sadistic behavior from them, the therapist's efforts to maintain the structure of the treatment are particularly difficult, and enormous efforts may be required to differentiate his interventions from the authoritarian behavior of the parents. A careful equilibrium between respecting the privacy of the adolescent's sexual behavior and protecting the adolescent from dangerous expression of it, maintaining confidentiality while remaining within the boundary of legal dispositions, is a major challenge that has to be confronted from the viewpoint of what are the minimum moves away from technical neutrality that protect the adolescent's well-being and the viability of the treatment.

Transference Analysis

As in the case of adults, it is important to interpret both positive and negative transferences to prevent that, with the strong predominance of negative transferences typical in severe personality disorders, the therapist conveys the impression to the adolescent that he is "all bad." This becomes particularly relevant in the case of severe narcissistic transferences, with their tendency of dismissal and devaluation of all the therapist's suggestions. To point out, for example, the adolescent's capacity to be openly critical of the therapist as a way to stress the positive aspects of courage in his communications may help a patient who otherwise feels that he is always involved with a critical therapist.

Transference interpretation usually starts out with significant exploration of transference displacements to external figures. The interpretation of the transference in relation to the therapist himself may be opened as a "playful" invitation to the adolescent to express in fantasy and playful action in the session what his experiences or thinking about the therapists is. It is important to foster the cognitive framing of the adolescent's feelings in this regard in terms of the adolescent's developmental level. The therapist may make an appropriate bridging from play to verbal, symbolic communication of the meaning of the adolescent's experience and their interaction. The therapist suggesting to the adolescent

that acting out behavior as well as somatization may, at times, express feelings that the adolescent wouldn't dare to express toward the therapist represents another bridging effort to bring these manifestations into a verbalized, affective, and symbolic context.

Countertransference

Countertransference, in its contemporary view, corresponds to the therapists total emotional reaction to the patient. In Kernberg's model a distinction is made between acute and chronic countertransference reactions. Acute reactions may manifest at a particular moment such as when the therapist is surprised by the intensity of the affect or the type of thought he might find himself having about the patient. Chronic reactions on the other hand is a much more stable emotional disposition towards the patient—these distinctions will be discussed further in our manual (Normandin et al., [in press](#)). The severity of the adolescent's acting out in the sessions and outside the sessions may promote strong countertransference reactions, reflecting concern both for the adolescent and over the risk that the treatment will be interrupted by adolescent's behavior that cannot be tolerated by the parents, and provokes their hostile reactions against the therapist. The intense, consistent dismissal and devaluation of the therapist's interventions in the case of adolescents with severe narcissistic personality disorder may, over a period of time, seriously disturb the therapist's sense of security, raising intense feelings of failure, and provoke the temptations to giving up on the adolescent. The therapist may lose sight of any positive transference manifestations. The adolescent's wishes for maintaining a dependent relationship with the therapist, in spite of the adolescent's constant attacks on him, may be missed. Erotic countertransferences to sexually seductive adolescent may disturb a therapist more than corresponding countertransferences evoked by adult adolescents, stirring up profound oedipal prohibitions against intergenerational activation of sexual desire. The therapist needs to tolerate these experiences in himself/herself in order to observe and come to understand them fully, and

neither act on them nor communicate them directly to the adolescent, but use these reactions as material to be woven into transference interpretations. The general preparedness of the therapist to be alert to the risk of either adopting a seductive “freedom fighter” attitude toward the adolescent or to become the “policeman” for inefficient parents should provide a general frame helping the therapist to maintain an objective stance regarding his countertransference temptations.

There are times when the treatment is “blocked.” There may be weeks of “non-understanding,” or a pervasive sense of hopelessness that interferes with the active work with transference and countertransference. Tolerance of such periods with an openness, at times, to share with the adolescent the impression that the treatment has come to a standstill may open up new information about transference and countertransference lines. There are adolescents with severe self-destructive tendencies and the unconscious tendency to destroy whoever tries to extend them a helping hand, associated with the syndrome of malignant narcissism that may seriously limit the effectiveness of the treatment. We have to accept that not everybody can be helped with this treatment, or even with treatment in general. The major prognostic indicators, corresponding to those for adults, are the adolescent’s remaining capacity for non-exploitive object relations, the absence of antisocial features and of secondary gain, and the adolescent’s intelligence and demonstrated potential for creative functioning in some areas. A supportive family environment may be a major positive contributing factor to supporting the treatment with a very disturbed adolescent.

Conclusion

TFP-A as we have described is a psychodynamic treatment that was adapted for adolescents following several studies that provide support for TFP as an evidence-based treatment for adult patients with BPD (Clarkin et al., 2004; Doering et al., 2010; Levy et al., 2007). In clinical practice we have been using

TFP techniques for adolescents over the past 20 years, but the impetus to formalize the treatment and its adaptations came initially from Paulina Kernberg who was convinced that early diagnosis and intervention with children and adolescents was both a priority and realistic. The present climate is much more favorable for diagnosing and treating BPD in adolescence, and early skepticism has been replaced by enthusiasm and encouragement for developing and adapting treatments for adolescence. The time is ripe for formalizing and describing the adaptations that clinicians have been making to existing treatments in order for their adolescent BPD patients also to benefit from manualized treatments. We are encouraged by the satisfaction of seeing adolescents resume a normal development, by the fact that clinical psychology students can be trained to apply this treatment model in their work with adolescents, by the spirit of cooperation between those working on adapting treatments for adolescents, as well as the scientific advances and interest in the development of this problematic at adolescence. We see the treatments as complementary, serving different populations, and with many common elements. While the treatments commonly address emotional regulation and mentalization, the unique component of TFP-A is its capacity to support normal development while addressing and changing the path of the development of personality through addressing extreme affects and split-off self and object representations. The effective integration of the adolescent’s self-concept and his concept of significant others, that is, the development of a normal ego identity corresponding to a normal adolescent developmental stage, will facilitate the adolescent’s resumption of normal psychological growth. It will show that the optimal features of TFP are not educational or reeducative efforts, but the establishment of the adolescent’s internal freedom to enrich his internal experience and develop creative relationships in school, work, love, friendship,

family, and social life. We have shown that it is possible to train graduate students in psychology to become competent TFP therapists with adolescents, and we are now conducting a study to collect evidence of the efficacy of TFP-A.

Appendix: Clinical Vignette

Case of Jacob

Jacob, aged 13½, was brought to the clinic by his parents after his school threatened to expel him because he physically assaulted another student. In spite of above average intellectual ability, he was failing at school and had a long history of oppositional behavior at school and at home. At home, his parents were at a loss as to how to deal with his swings from being oppositional, provocative, and argumentative to being stubbornly silent and passive aggressive, or overly dependent, infantile, and submissive at other times. They were also concerned about the extent to which he was bullying his younger brother. In addition he was eating uncontrollably and never seemed satisfied, and as a result was becoming increasingly overweight. In terms of his early history, his mother described him as a demanding and hypersensitive baby. Her first impression of him at birth was that there was something in the way that he looked at her that evoked a fear in her that he would suck her dry.

In therapy, Jacob habitually slouched in his chair and seemed to cut off and became morosely silent and exaggeratedly tired and sleepy the moment he entered the therapy room. This contrasted sharply with how he behaved when the therapist fetched him in the waiting room when he seemed evidently happy to see her, talking on the way to the therapy room about computer games, card collections, and television series and being obviously pleased when he could see that she knew what he was talking about. The main difficulty however was his extreme and prolonged silences during the sessions. While it is common for adolescents to be silent especially during the beginning phase of

treatment, in Jacob's case his silence went far beyond this. An intense paranoid reaction was apparent and he acts like someone who has been dropped behind enemy lines. Jacob used his silence so that he could feel in control of the relationship, and while this defended him from revealing and facing a much more sensitive dependent side, it also left him with a very restricted inadequate range of interpersonal responses, and evoked frustration and rejection in others, who felt devalued and treated as if they were trying to control him. His peers did not tolerate his superiority and haughtiness and humiliated and rejected him when he responded like that, something he was highly sensitive to and unable to defend himself from, except through aggressive retaliation.

The following extract is from a session after a humiliating experience at a summer camp where his characteristic stubbornness and refusal to participate in any activity provoked mockery and rejection from the other boys. For example, he refused to prepare for a 3-days survival excursion, something that could potentially place the other members of the group at risk. He found the rejection by his peers extremely humiliating and difficult to tolerate, but had no other strategy to repair and reinsert himself socially and consequently remained rejected and isolated. When he was no longer able to tolerate this situation, he phoned his father and asked him to come and fetch him.

In this session the therapist uses clarification, confrontation, and interpretation to address the dyad that Jacob sets up with the therapist where he induces her to become the controlling object.

Th: Do you have any further thoughts about the meeting we had with your parents?

Pt: No, but I guess we are obligated to talk about it. (The therapist had the impression here that this was said without hostility, and that Jacob actually wanted to speak about it, but that he would only do this in the context of an interrogation where he set up a dyad, where he was the victim and the therapist the torturer).

Th: Does it mean that you don't want to share your thoughts because you have the impression that I am forcing you?

decided to win that battle. But do you see how this side clashes with the one side at the camp who could not tolerate being joke at and humiliated. So, there is that part of you that is very “defiant,” very “arrogant” as your parents would say, and that other part of you that is very very sensitive, easily hurt, and defenseless. What do you think? . . . Is it possible?

Pt: (mumbling) It is possible! I don’t know. . . . Anyway, what is the problem?

Th: I guess we have a problem. I say “we” because I think that what happened at the camp is serious because it shows a part of you that needs help to learn to protect yourself. But when I offer my help you don’t see it like help, you have the conviction that I will humiliate you even more, that I won’t let you say what you want to say. . . that I will do whatever I want with you, that I will force you to talk, that I will torture you. . . So we have a problem because it seems like the only way you think you can protect yourself from me is to stand up against me. It is okay in a way because I think you get some sort of a reassurance from that. It is like saying to yourself: “So it is me who is in control here, nothing will happen to me! It is OK. . . in the sense that you communicate something important there, but deep down, there is a problem. . . And the problem is that it is your only card. When you get into a situation like that, let’s say with your parents for example, . . . they react quite strongly when you enact this role because you don’t have any other card in your pocket. With your classmates, or with the other boys at the camp, you couldn’t use that card, or maybe you used it, I don’t know. But, am I right if I say that if you were inflexible with them, they will go away or they will continue to provoke you and hurt you.”

Pt: That is true. They were laughing at me.

Th: Your card, the only card you have in your game, which is to be opposed. . . to stand up. . . was not working there and it left you exposed.

Pt: Hum, hum. . . yes.

Th: Yes! . . . I find you quite courageous for saying “yes” like during the meeting with your parents, I also found you courageous for tolerating being there with them while they

were obviously angry and depreciative of you. Courageous for staying there. You didn’t subside into your chair, you didn’t fall asleep. You did not provoke your parents too much. You were able to tell me enough about what happened with the boys at the camp and the issue around your French accent so much so that I could understand how difficult it must have been for you at camp. I found you courageous because you, in a way, admitted that it had nothing to do with finding the camp boring, that it had nothing to do with the fact that it was not what you were expecting.

Pt: (looking engaged and interested).

Th: And I don’t know if you had noticed something then, but your father changed his attitude towards you just before the end of the meeting. He mentioned that you have expressed remorse for having him to drive all the way to the camp to fetch you and that you were searching somehow for ways to repair it by offering to pay for the expenses.

Pt: I know, I remember.

Later in the session:

Th: I wonder if we can understand that famous incident where you assault one of your classmates last fall. I wonder if there is a link between being unable to protect yourself when you feel humiliated and exploding? . . . You know between the fact that this person had probably provoked you by humiliating you and that the only way you could find at that moment, to stop the torture, to protect yourself was by hitting him. . .

Pt: Yes, he did not want to stop. The girl too, was provoking me (revealing by the same token that he had been assaulting at least one other classmate).

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